

**Chesterfield County Public Schools
Office of Student Health Services**

Request for Individualized Healthcare Plan

Dear Parent/Guardian:

Providing a safe, supportive and nurturing environment is a goal of Chesterfield County Public Schools (CCPS). The health information provided for your child indicates that he/she has a health concern. To adequately meet your child's health needs while in school, please do the following as soon as possible:

1. Have your licensed healthcare provider (physician, physician's assistant or nurse practitioner) complete and sign the attached Individualized Healthcare Plan (IHP). IHPs are also available online at <http://mychesterfieldschools.com/parents/student-health-and-safety/>.
2. Provide your signature on the IHP.
 - You understand school staff and/or the school health nurse may communicate with the Licensed Healthcare Provider/medical office staff about the IHP.
 - You understand you are responsible for providing the school with all medication for your child in the original container per Chesterfield County School Board policy 4130/4130R *Administration of Medication to Students*.
 - You understand you are responsible for completing the Chesterfield County Public Schools School Medication Record for medication ordered in this health plan.
 - You understand emergency medication you provide will be administered as ordered by the Licensed Healthcare Provider.
 - You agree to the IHP for your student.
3. Return the completed plan to the attention of the school nurse at the school your child will be or is attending.

It may be necessary for some students to carry and self-administer emergency medication. This requires proper documentation by a licensed healthcare provider on the appropriate health plan. Permission for a student to possess and self-administer medication (for example auto-injectable epinephrine or medication to manage asthma or diabetes) is effective for one school year and must be renewed annually. Please consult with your school nurse for details.

If medication is needed for your child, complete the CCPS School Medication Record form required for all medications that students take during the school day. This form is available in the school clinic and at <http://mychesterfieldschools.com/parents/student-health-and-safety/>. Medication must be provided by the parent/guardian and brought to school by the parent/guardian in the original appropriately labeled container. See the CCPS website for details regarding the medication policy and regulation (4130 and 4130R).

For students with a life-threatening food allergy, the Food Allergy Medical Statement must be completed by a physician, physician's assistant or nurse practitioner if the child needs any of the following: to be identified by cafeteria staff as having a life-threatening allergy; if child is lactose intolerant; if substitutions or food modifications need to be made in the school breakfast or lunch programs. The Cafeteria Manager at school must also be notified. For assistance you may contact the Nutritionist, CCPS Food & Nutrition Department, at (804) 743-3717.

A health condition may be considered a disability. If you suspect your child may have a disability, ask your child's teacher, Counselor, school nurse or administrator for a referral to consider eligibility for 504 or special education services.

If you have any questions, call the registered nurse at your child's school. We appreciate your prompt attention to this matter. Thank you for partnering with us to support your child's well-being in school.

1st notice _____

2nd notice _____

Attachment

Sincerely,

Chesterfield County Public Schools
Office of Student Health Services

Individualized Healthcare Plan
effective for the current school
year, including summer school.

Chesterfield County Public Schools
Office of Student Health Services
Individualized Healthcare Plan - General
Page 1 of 2

Student Name:

Date of Birth:

Grade:

To be completed by Licensed Healthcare Provider (Physician, Physician's Assistant or Nurse Practitioner).

Health Status	Diagnosis:
	Description of the student's medical condition:
	Please list any physical, emotional, developmental, behavioral and/or communication concerns:
	Relevant medical history: Surgeries _____ Hospitalizations _____ Allergies (medications or other)
Activity	Is this student medically able to attend school? <input type="checkbox"/> Yes <input type="checkbox"/> No Full day? <input type="checkbox"/> Yes <input type="checkbox"/> No Comment:
	Are there any expected absences related to what is described in health status? <input type="checkbox"/> Yes <input type="checkbox"/> No Comment:
	Full Participation in Physical Education classes and/or recess? <input type="checkbox"/> Yes <input type="checkbox"/> No Comment:
Emergency Plans	Please indicate any medical interventions necessary in the event an urgent situation requires immediate action:
Transportation	Can student ride the school bus? <input type="checkbox"/> Yes <input type="checkbox"/> No Is any special assistance (personnel or equipment) needed on the bus? <input type="checkbox"/> Yes <input type="checkbox"/> No Comment:

Parent/guardian collaborates with the RN School Nurse and student's healthcare provider to review and demonstrate procedures to designated school staff.

Continues on Page 2

Student Name: _____ M or F Date of Birth: _____

For students with G-tubes, J-tubes, colostomy/ileostomy care, catheterization, seizures or trach care, an additional specific Medical Order form or Individualized Healthcare Plan must be completed. Contact School Nurse regarding additional forms.

Procedures	Dietary	Musculoskeletal	
	<input type="checkbox"/> Gastrostomy tube* feeding <input type="checkbox"/> Nasogastric tube* feeding <input type="checkbox"/> Jejunostomy tube* feeding <input type="checkbox"/> Oral Feeding Plan and/or Special Dietary needs- call Office of Exceptional Education at 639-8918 and Office of Food Nutrition 743-3717 * Order for Tube Feeding Management at School needs to be completed in addition to this IHP.	School	Bus
		<input type="checkbox"/> Cane <input type="checkbox"/> Crutches <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Prosthesis <input type="checkbox"/> Orthosis <input type="checkbox"/> Cast care <input type="checkbox"/> Body mechanics/repositioning	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	Elimination	Respiratory	
	<input type="checkbox"/> Colostomy care <input type="checkbox"/> Ileostomy care <input type="checkbox"/> Diapers or Pull ups (please circle) <input type="checkbox"/> Clean Intermittent Catheterization** <input type="checkbox"/> Indwelling urinary catheter* <input type="checkbox"/> External urinary catheter <input type="checkbox"/> Urostomy pouch <input type="checkbox"/> Catheterizing a stoma *Only an RN or LPN may reinsert or remove an indwelling catheter with a physician's order and proper training. If dislodged, notify parent. ** Order for Catheterization needs to be completed in addition to this IHP.	School	Bus
		<input type="checkbox"/> Oxygen <input type="checkbox"/> Nasal cannula <input type="checkbox"/> Oxygen mask <input type="checkbox"/> Pulse oximetry <input type="checkbox"/> Trach care/suctioning** <input type="checkbox"/> Suctioning <input type="checkbox"/> Chest Physiotherapy <input type="checkbox"/> Ventilator Machine ** Order for Tracheostomy Care needs to be completed in addition to this IHP.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
		Neuro	
		School	Bus
		<input type="checkbox"/> Rectal Diazepam <input type="checkbox"/> Vagal nerve stimulation <input type="checkbox"/> Ventricular Shunt monitoring	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Please describe procedures required to be done during school hours. Include equipment and time intervals.			

Current Meds	Medication	Dose	Route	Time

Licensed Healthcare Provider - Print name	LHP Signature	Date	NPI #	Phone
<i>Additional healthcare providers/specialists involved with this student's health care:</i>				
Name (Print)	Specialty	Phone		

To be Reviewed and Signed by PARENT/GUARDIAN:

I have reviewed this health plan and the *Request for Individualized Healthcare Plan* and agree to the contents.
 A health condition may be considered a disability. If you suspect your child may have a disability, request a referral to consider eligibility for 504 or special education services.

Parent Name (Print)	Parent Signature	Date	Phone
---------------------	------------------	------	-------

School Nurse Name/Signature _____ Date Received _____ Date EAP Distributed _____